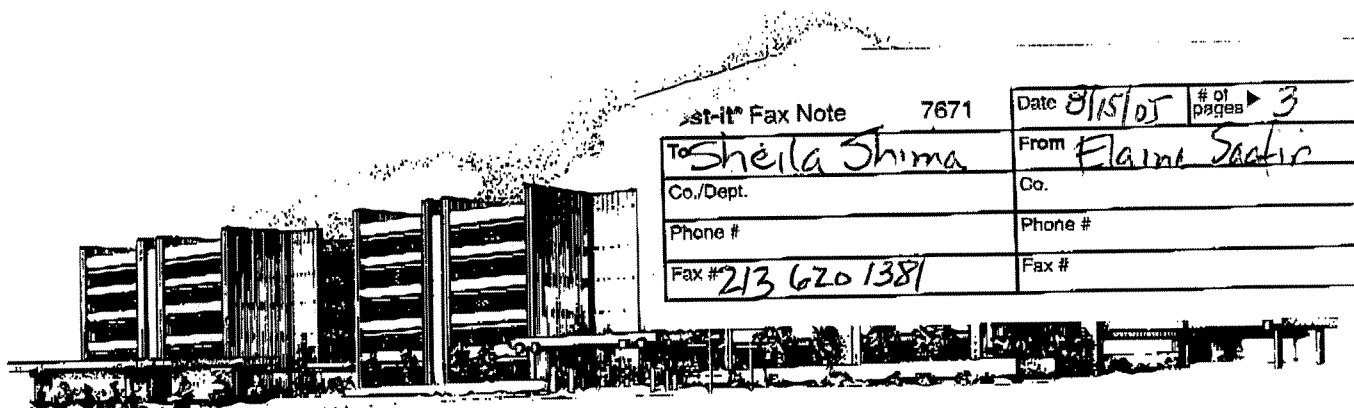


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MARTIN LUTHER KING, JR. / CHARLES R. DREW MEDICAL CENTER 12021 South Wilmington Avenue Los Angeles, CA 90059 310 / 668-4321

August 11, 2005

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

ACTIONS BY THE HAB AT ITS AUGUST 10, 2005 SPECIAL MEETING

We are writing to report to you the actions taken by the King/Drew Medical Center Hospital Advisory Board ("the KDMC HAB") at its Special Meeting of August 10, 2005. This Special Meeting was convened for the purposes of completing the HAB deliberations on the recommendation made by the LAC DHS Director/CMO to downsize KDMC as outlined in his report to your Board dated August 5, 2005.

The HAB is concerned about the inconsistent process of including the HAB in the development of proposals, issue analysis, or other decision-making in matters pertinent to the HAB's charge as the governance structure for KDMC.

In particular, two recent items highlight our concern:

1. The Auditor-Controller Report on Navigant Consulting, Inc. to your Board of June 13, 2005
2. The Director's Recommendation to downsize KDMC, report of August 5, 2005

In the former, the HAB was apprised of the audit results after the report had been sent to your Board. Consistent with our charge as an advisory board, the HAB believes that we must provide our best opinions and analysis on such recommendations made by LAC DHS and Navigant to the BOS. In order to do so, the HAB members feel it would be more appropriate that such reports be reviewed by the HAB prior to being submitted to the BOS. In this way, the HAB hopes to provide the BOS with all the necessary information needed to make appropriate decisions on the future of KDMC.

As for the latter item, the report including the recommendation to downsize KDMC was made public on August 4, 2005. However, the full report was not available to HAB members until late in the day August 5, 2005. In addition, the LAC DHS Director did not formally present the recommendation to the HAB until the regular meeting of the HAB on August 8, 2005. Although the HAB Chair, Vice-

Honorable Board of Supervisors
August 11, 2005
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Chair and KDMC Interim CEO were invited to three KDMC planning meetings by DHS, their participation did not imply an endorsement of the ideas being discussed at these meetings, and much less a formal approval by the HAB to make such recommendations.

Accordingly, upon confirmation of a quorum present including the Chair and the Interim CEO, the HAB took the following actions for your Board's consideration:

It was moved and seconded that:

1. Recommendations regarding any activity that would affect the governance, management, and/or patient service delivery model at King-Drew Medical Center shall be formally submitted to the Hospital Advisory Board (HAB) for its advice prior to submission to the Board of Supervisors (BOS) for action, except where the Director of Health Services finds and declares that failure to take immediate action would place patients and/or employees in harm's way. The Director shall include the HAB's advice and recommendations in his written communications to the BOS.

Motion carried on a 7-0 vote.

It was moved and seconded that:

2. The HAB recognizes that the recommendations submitted by the Director of Health Services regarding the future of King/Drew Medical Center are a response to a directive of the BOS and that a short timeframe for their development was given. Further, the HAB supports the Director and his staff in their efforts to restore King-Drew Medical Center's service delivery programs and the hospital's accreditation. In that regard, we request that the BOS grant the Director and his staff more time to develop and vet his recommendations with the HAB.

Motion carried on a 6-0 vote with one abstention.

It was moved and seconded that:

3. The HAB opposes the Director's recommendations that include the reductions of in-patient service delivery at KDMC as proposed in his report to the Board of Supervisors on August 5, 2005.

Motion carried on a 6-1 vote.

We have been instructed by the members of the HAB to convey the context and content of these actions and to request that your Board approve a motion to establish the process for a direct reporting relationship of the HAB to your Board.

Second, the HAB requests that the Director be given additional time to complete the gathering of data to support his recommendations and to confirm the underlying assumptions about the capacity of other county facilities and/or private sector facilities to assume the care of patients (in the immediate and long-term future) displaced from KDMC as a result of service reductions at the KDMC.

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Lastly, the HAB opposes the Director's August 5, 2005 recommendations for service reductions at KDMC because they threaten the stability of the institution at a critical time and because the long-term impact of any reduction in services on the community of South Los Angeles has not been adequately studied. Although the HAB recognizes the potential need for future reductions in services at KDMC, we oppose the specific recommendations made in the Director's August 5, 2005 report.

Thank you for your attention to these matters.

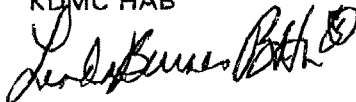
Sincerely,



Hector Flores, MD, Chair
KDMC HAB



Jim Lott, Vice-Chair
KDMC HAB

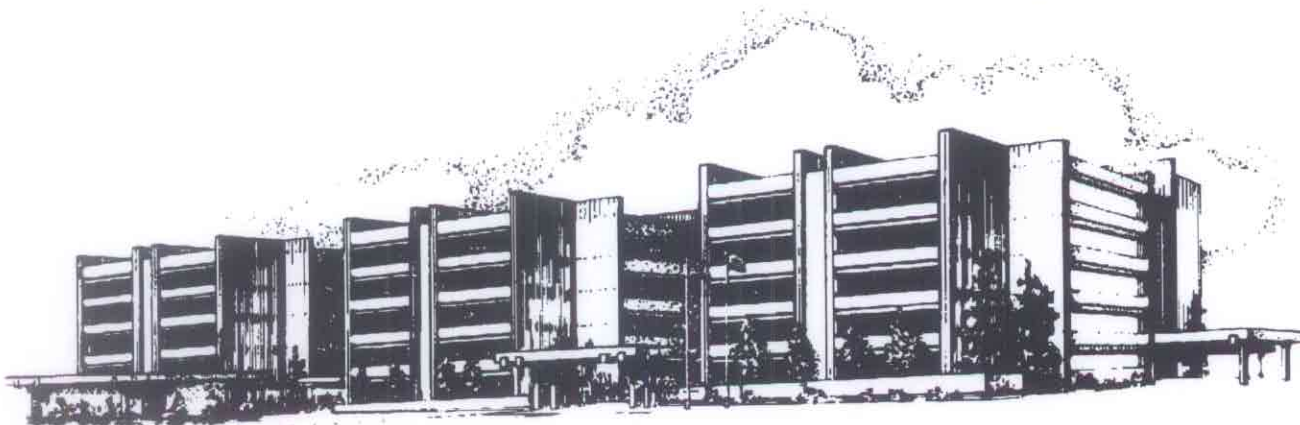


Linda Burnes Bolton, DrPH, RN, Secretary
KDMC HAB

HF:JL:LBB:ah

c: KDMC HAB Members

S-1 of 8-16-05



MARTIN LUTHER KING, JR. / CHARLES R. DREW MEDICAL CENTER 12021 South Wilmington Avenue Los Angeles, CA 90059 310 / 668-4321

September 30, 2005

TO: Each Supervisor

FROM: Hector Flores, MD, Chair
KDMC Hospital Advisory Board

Jim Lott, Vice-Chair
KDMC Hospital Advisory Board

Linda Burnes Bolton, D.P.h., RN, Secretary
KDMC Hospital Advisory Board

SUBJECT: **LAC DHS RECOMMENDATION FOR THE FUTURE OF KDMC**

The KDMC Hospital Advisory Board (HAB) held a special meeting on Wednesday, September 28, 2005, to discuss and take action on your Board's request "... to provide written comments on the Director's recommendation or any alternatives to those recommendations by September 30, 2005 and that the Director provide his written response to those comments by October 7, 2005 ..."

Included herein are our written comments on the Director's recommendation, in lieu of an "alternative" proposal to the LAC DHS plan. We believe that planning for the future of KDMC must contextualize hospital-specific planning within a broader system-wide strategic planning initiative for County health.

The HAB has made a finding that the potential benefits, if any, of the recommendation to close inpatient maternal and child health services do not clearly link to the immediate concern about an adverse action by CMS, California State Licensing, and/or JCAHO and they do not outweigh the distraction created from what the HAB has identified as its most immediate goals: mitigating the deficiencies identified by CMS, California State Licensing, and JCAHO, stabilizing the hospital, and ensuring its continued funding and re-accreditation.

The HAB is steadfast in its opinion that the response to CMS, State Licensing, and JCAHO concerns must encompass a clear and convincing set of initiatives that address the leadership, management, medical staff, human resources and accountability gaps at the institution, notwithstanding size or scope of services. To that end we have identified the following priorities:

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- Attention to management systems including recruitment and orientation of the new CEO and an orderly transition of the NCI team;
- Focused recruitment, retention, training and education strategies for KDMC and a focused employee discipline and remediation strategy for administrative and clinical personnel;
- A commitment to clinical excellence, rigorous review of clinical practice, and a safe environment of care;
- Comprehensive planning for the future size and scope of services at KDMC.

We have established committees to address these priorities. As such, additional consideration of the LAC DHS recommendations will be integrated into the work of HAB committees.

As you will note from the attached document, the HAB has afforded the LAC DHS recommendation the considerable time and deliberation that it requires, and the body of our data and information requests has been shared with the LAC DHS Director, in draft form on August 10, 2005 and in its subsequent iterations in order to provide him and his staff ample time to gather the requested information and to submit to your Board his written response by October 7, 2005.

In particular, the HAB has asked the Director to provide the necessary data and information regarding the following:

1. Can the private sector and Harbor-UCLA "pick up the slack" of Pediatric and OB/Gyn admissions that will no longer be served at KDMC?
2. Are private sector hospitals equipped to take care of a higher volume of obstetric patients with (expensive) prenatal complications, perinatal complications, and critically ill neonates?
3. Are private physicians in those hospitals able or willing to take care of indigent patients self-referred to them for admission once they or a family member have received services at those private facilities?
4. Will Medi-Cal Managed Care physician networks (Independent Practice Associations – IPAs) pick up the slack for services normally indirectly subsidized by LAC DHS facilities?
5. What will be the impact of downsizing the KDMC on the residency programs in Pediatrics, OB/Gyn, Family Medicine and on the Fellowships in Neonatology? And on the LAC DHS academic partner, Drew University?

At the September 28, 2005 HAB special meeting, and after confirming the presence of a quorum including the Chair and the Interim CEO, the HAB reviewed the content of the Director's letter to your Board dated August 5, 2005 and his letter to your Board dated September 21, 2005. The Director also provided a narrative update on the issue and indicated that he would review the attached document of HAB questions and concerns once again to ensure that he could fully respond to the data and information requested by the HAB.

The HAB welcomes the progress made by the LAC DHS in finding supportive evidence for the underlying assumptions that led to the DHS recommendation to close inpatient maternal and child health services at KDMC. However, the HAB also notes that the information gathering is not yet complete. The Director indicated that he did not foresee major difficulties responding to the remaining questions but he will apprise the HAB if he were to encounter any problems in completing this task.

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At the special meeting of the HAB on September 28, 2005 it was duly moved and seconded to submit the attached document with this cover letter to your Board. The motion carried by a 7-1 vote.

HF:JL:LBB:hf

Attachment

c: Thomas L. Garthwaite, MD
HAB Members

The HAB Questions Regarding the LAC DHS Proposal for Closing Inpatient Maternal and Child Health Services at KDMC

Submitted to HAB Members 9/2/05

Consistent with the motion adopted by the Board of Supervisors on Tuesday August 16, 2005, the HAB submits this response to the LAC DHS proposal for the downsizing of KDMC as the "last, best hope" of keeping crucial hospital services open for the people of south Los Angeles.

In preparing this report, the HAB takes into consideration:

1. The immediate priority of ensuring successful Center for Medicare and Medicaid Services (CMS) review once the existing Memorandum of Understanding expires,
2. The critical importance of preparing for a successful review by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) and the Accreditation Council on Graduate Medical Education (ACGME),
3. The time pressures experienced by the LAC DHS to correct the deficiencies in the operation of the KDMC,
4. The impact that the proposed downsizing of KDMC will have on the people of south Los Angeles, on the financial viability of the KDMC once its size is reduced, and the impact that this reduction would have on the production of physicians and other health professionals who are willing to serve vulnerable populations, and
5. The validity of the data and underlying assumptions utilized by the LAC DHS to reach its recommendation to downsize the KDMC.

In addition, the HAB is concerned that the recommendation to downsize the KDMC is based on a perceived urgency to "do something" rather than on a strategic "rightsizing" of the KDMC in a manner congruent with long-term Countywide priorities and with the health care needs of the people of SPA 6.

Background

Given the complexity of the challenges at KDMC and the pending review by the Center for Medicare and Medicaid Services (CMS), the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Council on Graduate Medical Education (ACGME), the HAB appreciates the fact that the Board of Supervisors (BOS) has to be willing to consider any and all options for preserving such hospital services.

However, based on our discussions and actions at the August 10, 2005 special meeting of the HAB -- and while we share the urgency that the LAC DHS and Navigant Consulting Inc. have to resolve the *internal* issues at the medical center -- the spectrum of health care needs in south Los Angeles and the dearth of providers willing to meet those needs calls for a broader, more detailed analysis of the impact of the recommendation to downsize KDMC into an adult inpatient medical center.

We are concerned that the LAC DHS is moving towards the downsizing of KDMC with insufficient information about the rational changes that need to be made *internally*, and with insufficient information about the *external* consequences of this decision, including putting the LAC DHS at risk of breaching its obligation to serve the people of south Los Angeles. The LAC DHS also needs to complete an analysis of the *long-term* impact of the downsizing of KDMC on the entire county of Los Angeles.

For example, the future financial viability of the “downsized” KDMC is in question, if the loss of insured/covered patients continues, as is the presumed availability of private sector services to “pick up the slack”. We are concerned that the downsizing of the KDMC is proposed purely from a reactive perspective, not as part of a systematic re-engineering of what ails the County health system – from the LAC DHS on down to the individual hospitals and the private sector – and what should be the basket of services that the LAC DHS is responsible for throughout the County.

If the infra-structural changes that the KDMC needs are not made in concert with a broader vision, or if we move aimlessly to cripple the KDMC’s financial viability, then all we have done is downsized our ability to fix the problems at KDMC and within LAC DHS.

The HAB Chair and Co-Chair and the Interim CEO were invited to attend a series of DHS meetings in late July 2005 to discuss the future of KDMC. At these meetings as well as in separate conversations the Chair and Co-Chair asked the DHS Director and DHS staff to outline their underlying assumptions and find the evidence to support those assumptions before a recommendation should be made to the BOS.

Although the HAB did not submit a formal written request for this information at that time, these questions were raised in those July meetings and they were not answered:

1. Can the private sector and Harbor-UCLA “pick up the slack” of Pediatric and Ob/Gyn admissions that will no longer be served at KDMC?

- a. Today?

The DHS indicates that the KDMC is *de facto* operating as a “downsized” hospital because of the extremely low pediatrics and obstetrics census.

We are concerned that the summer months are not an indicator of future volume needs, particularly in the winter months (see below). And the lack of patient complaints related to having to use alternative sources of care is more a reflection of the disenfranchised patient population of south Los Angeles, not an absence of problems. In general, the people of south Los Angeles are not empowered to complain when they are denied service elsewhere or when they have to ride long distances (or take multiple buses) to different county facilities.

Only time will tell what will be the true impact on these individuals.

What is of concern is that a proposal to downsize is based on limited data extracted from a narrow window of time (the year 2004) when the KDMC experienced the loss of JCAHO accreditation and the subsequent loss of Medi-Cal Managed Care patients, when it experienced negative media coverage, and when it lost many physicians to the private sector or to other facilities.

In addition to the liability assumed by LAC DHS when it actively plans to transfer acutely ill children, infants and pregnant women to other facilities, this proposal could severely affect the health status of the fast-growing population of SPA 6.

- b. In the ensuing 12 months with the anticipated cyclical increased demand for hospitalizations such as the winter months when the “Flu Season” hits?

Each winter the entire County of Los Angeles experiences a shortage of acute care beds in hospitals throughout the area. This is due to the so- called “Flu Season” when more patients,

young and old alike, require hospitalization for pneumonia, chronic lung disease and asthma exacerbation (usually as a complication of the flu), and it is during these months that many infants require admission to a hospital because of serious viral infections.

What is the expected number of hospitalizations for patients living in the area, and which local facilities have committed to provide that care?

- c. In the ensuing 12-18 months when more private hospitals close or downgrade their Emergency Rooms, or worse, close their doors entirely?

The past 18 months have seen the closure of major area hospitals including Santa Marta, Robert F. Kennedy, Northridge, and Brea Hospital (in Orange County). The Hospital Association of Southern California (HASC) members report that as many as eight hospitals are at risk of closing, including six that are designated as Disproportionate Share Hospitals (DSH). Many more are believed to be on the brink. All of these closures will add to the shortage of available beds in the area.

Other hospitals are threatening to close or downgrade their Emergency Rooms. In the early part of August 2005 the Downey Regional Medical Center announced the possible closure of its Emergency Room due in large part to the displacement of indigent patients from the KDMC service area after the closure of the KDMC trauma center. Similarly, the Hospital of the Good Samaritan is carefully deliberating on the future of its Emergency Room services.

Emergency Rooms are the portal for admission of the most acutely ill patients and they are the portal for indigent care in private hospitals.

- d. In 2007 when the LAC DHS budget deficit reaches nearly a billion dollars (by some accounts) and the BOS has to set aside money to ensure the funding of the retirement benefits of future and present retirees?

This is the aspect of downsizing KDMC that is the most ominous, for a downsized KDMC will become an increasingly indigent care hospital – a Community Hospital with safety net obligations for those uninsured patients least likely to qualify for public programs – with potentially unsustainable costs under the severe budget crisis expected in 2007.

The very real possibility of dooming KDMC to eventual closure by downsizing it today has not been fully evaluated. The impact on the rest of the County then needs to be considered as well.

Inner city, safety net hospitals are financially at risk across the nation, and many observers suggest that the partnership represented in the Academic Medical Center (AMC) model can positively affect the financial stability of KDMC by pulling in conventional – though limited – patient care revenues available to county hospitals in medically underserved areas and conventional (for AMCs) academic center revenues such as research grants, clinical trials, teaching hospital charge masters (e.g., higher specialty hospital rates for ICU, Pediatric ICU, and Neonatal ICUs), and managed care carve-outs.

In addition, only an AMC model allows for a university-owned and university-accountable Faculty Practice Plan that supports the medical center's quality initiatives, its teaching quality and accreditation requirements, and that contributes to the medical center's financial viability.

The HAB would like to see a comparison of financial *pro forma* for an AMC and a similarly sized Community Teaching Hospital.

2. Are private sector hospitals equipped to take care of higher volume of obstetric patients with (expensive) prenatal complications, perinatal complications, and critically ill neonates?

The Medi-Cal patient population presents a financial challenge for the treating hospital and its physicians. While most hospitals and Obstetricians are willing to treat normal pregnancies and normal deliveries covered by Medi-Cal, they are not uniformly equipped to handle complicated pregnancies or sick premature babies or the costs related to their care.

Providing care to complicated pregnancies and to critically ill newborns is a very expensive proposition, for it requires specialized units and nurses, a well-trained team of Perinatologists and Neonatologists, and highly regulated requirements for special programs such as the California Children's Services (CCS). Newborn critical care also requires Pediatricians and Pediatric subspecialists who are willing and able to care for the complex illnesses of these infants once they "graduate" from the neo-natal intensive care units. Because of the high cost of caring for these patients and the low Medi-Cal reimbursement, many hospitals are downsizing their own services or eliminating them altogether. Even private Disproportionate Share Hospitals (DSH) are having trouble managing the costs of these special needs patients despite the additional DSH funding.

At the very least, we would like to see a process established by LAC DHS that includes letters of intent specifying hospital capacity and medical staff physician capacity from hospitals most likely to assume the care of the pediatric and obstetrics patients normally seen at KDMC. The solutions to the County's problems have to be implemented in partnership with the private sector and with a clear understanding of the private sector hospitals' limitations and the precarious financial situation many of them are experiencing.

3. Are the private physicians in those hospitals able or willing to take care of indigent patients self-referred to them for admission once those uninsured patients or a family member have received services at those private facilities?

A by-product of establishing referral patterns of patients for normal deliveries and pediatric admissions is the "adoption" of those hospitals by the family members of the patients previously treated there.

The patient population being diverted from KDMC will surely include a large number of uninsured families that will now self-refer to those facilities instead of to KDMC, particularly under serious or emergency circumstances where they will not be easily transferred to a county facility.

In this regard, we ask that the DHS evaluate a troubling trend in the private sector. Several private hospitals in LA County are having difficulty ensuring basic specialty care through their Emergency Rooms. This threatens their Emergency Room licensure. Many hospitals have resorted to paying specialists to take call through their Emergency Rooms and to accept uninsured patients. Some of these hospitals are even having trouble getting their specialists to care for HMO patients, particularly Medi-Cal Managed Care (HMO) patients.

We do not feel that DHS has made the appropriate inquiries of private physicians, particularly badly needed specialty care physicians, to ascertain if they are prepared to "pick up the slack".

4. Will Medi-Cal Managed Care physician networks (Independent Practice Associations – IPAs) pick up the slack for services normally subsidized by LAC DHS facilities that will be needed by all women and children diverted to private hospitals?

Another troubling trend is the scarcity of many specialties in California, particularly in medically underserved communities where Medi-Cal is the primary coverage for low-income families. With the exception of Obstetricians, Medi-Cal payments are not considered adequate reimbursement by most private specialty physicians.

It is not unusual for specialties in short supply to demand that the Medi-Cal managed care physician networks or IPAs pay top dollar for their services. The typical IPA response is not to contract with those doctors. Instead, these IPAs look for contracts with specialists in large public teaching hospitals where the Medi-Cal services are indirectly subsidized. The result is limited patient access to those facilities because they are often a long drive, or worse, several bus transfers away from where the patients live or work.

In further evidence of this, the ambulatory care safety net – anchored by free and community clinics and federally qualified health centers – is also experiencing a worsening access to specialty services for their patients. Recently, one such trade association, the Southside Community Clinic Coalition, has been trying to parlay the desirability of their obstetrics patients and normal deliveries into a cooperative agreement with specialty networks, but it has experienced a similar response in negotiating with private specialty physicians.

Thus we are not as confident that the private sector is ready for the demands that the downsizing of KDMC would create.

More broadly, the HAB believes that the LAC DHS should develop a strategy to attract more Medi-Cal Managed Care patients to KDMC. This means not only recouping the Medi-Cal Managed Care patients typically represented in the women and children's Medi-Cal categories that were lost via HMO contracts, but also aggressively positioning the KDMC to retain its Medi-Cal adult patient population that is currently being considered for Medi-Cal Managed Care.

5. What will be the impact of downsizing the KDMC on the residency programs in Pediatrics, Ob/Gyn, Family Medicine and the Fellowships in Neonatology? And on the academic partner, Drew University?
 - On July 1, 2005, KDMC matriculated a new complement of resident physicians in Pediatrics, Ob/Gyn, and Family Medicine, incurring an obligation to train these new physicians.
 - In addition, resident physicians and the faculty members responsible for teaching them are a critical component of access to care for uninsured patients and their families at the KDMC and in their ambulatory care clinics.
 - The loss of these residencies will also have an impact on the Drew-UCLA medical students, for if there are no residencies and no patients, there is no teaching. Consequently, the UCLA School of Medicine may feel compelled to pull the medical students out of KDMC.
 - The financial impact of the loss of the residencies and the medical students would be devastating to Drew University and perhaps would lead to its closure.
 - The adverse effect on Drew University would threaten the unique relationship between Drew and KDMC that has distinguished the "KDMC Complex" as an academic partnership with the capacity to recruit socially committed, academically qualified faculty members who, in turn, actively recruit socially committed and academically qualified medical students and resident

physicians, most of whom are from racial and ethnic groups known to be under-represented in the health professions.

- This unique training environment combining the presence of a multi-cultural, economically disadvantaged patient population with a medical center and a medical school committed to serve California's neediest communities, has proven to be a model for recruiting and retaining culturally competent physicians in medically underserved areas.
- The elimination of these training programs will significantly reduce the number of culturally competent Pediatricians, Neonatologists, Obstetricians, and Family Physicians serving the people of Los Angeles County. Indeed, the very hospitals in the private sector that are expected to "pick up the slack" created by the downsizing of the KDMC are heavily dependent on KDMC graduates to join their medical staffs.

In closing, we have raised all of these issues with the DHS leadership team in order to assist the Board of Supervisors and the LAC DHS in setting the appropriate priorities for the KDMC. Clearly, our immediate challenge is successful performance on the CMS audit, regaining JCAHO accreditation, and achieving a successful review by the ACGME on their site visit. In each of these instances, successful passage is predicated on a systematic re-engineering of hospital operations in all wards, at all times. Simply amputating selected services based on incomplete data does not address the fundamental changes that CMS, JCAHO, and the ACGME expect to see on their respective visits.

The HAB sees the CMS, JCAHO, and ACGME priorities as achievable if the energy of the LAC DHS is focused on:

1. A top-to-bottom restructure of management systems at KDMC and that DHS ensures a successful orientation of the new CEO and a successful transition from the NCI management team
2. A decentralized Human Resources function that allows focused recruitment and retention strategies for KDMC and a focused employee discipline and remediation strategy
3. Developing a tangible Management-Labor partnership that emphasizes a safe environment of care and a commitment to clinical excellence
4. Developing an organized Faculty Practice Plan (FPP) that is accountable for a work-product that provides excellence in teaching, quality of care, and research
5. Utilizing the FPP as an anchor for the aggressive recruitment and retention of managed care patients at the KDMC
6. Developing a strategic plan for Graduate Medical Education (GME) at all LAC DHS hospitals that reflects the health care workforce needs in LA County and that emphasizes collaboration among public and private teaching hospitals

Finally, the HAB wishes to reiterate that the multiple effects of the downsizing of KDMC would be local and countywide, and in all likelihood, irreversible. It is for these reasons that we have asked your Board to allow the Department of Health Services more time to complete its due diligence. We not only need this basic information for the immediate future, but we should be planning the re-invigoration of KDMC in concert with a strategic plan for the entire County of Los Angeles.

In the absence of this necessary background information the HAB remains opposed to the August 5, 2005 proposal by the LAC DHS to downsize the KDMC.